Name/HI Number	Date Claim Received	Date Claim Paid	Clean Claim?	Claim Paid in 30 days?	If no, was interest paid?	If non-clean claim, paid in 60 days?	Appeals notice sent if not processed in 60 days?	Correct Appeals language provided?	Claim Processed Accurately?	Comments

Standard: 95 percent correct. Determination: Transfer results of this sample to the appropriate requirements at CP01 - CP04 of the *Review Guide*. See Column Explanations for requirements related to specific columns.

Requirement:

The M+CO must assume financial responsibility for emergency, urgently needed services, post stabilization care as well as temporarily out of area renal dialysis that its Medicare enrollees obtain outside the M+CO without prior authorization.

The M+CO must assume financial responsibility for any POS-related services that its Medicare enrollees may obtain, with or without prior authorization, depending on plan coverage rules.

The M+CO must make accurate determinations of "clean" and "non-clean" claims so that clean claims are not developed.

The M+CO must pay 95 percent of "clean" claims from unaffiliated providers within 30-days.

The M+CO must ensure that its contracting providers pay clean claims from unaffiliated providers within 30 days of receipt.

Purpose: To determine whether the M+CO: (1) complies with the regulatory requirement to pay for services covered by its subscriber agreement and for emergency post stabilization care as well as temporarily out of area renal dialysis, and urgent needed care; (2) pays clean claims within statutory requirement; (3) makes accurate decisions regarding what is a clean claim; and (4) pays POS-related claims from unaffiliated providers and suppliers, if applicable, and (5) sends written notice of adverse organization determination within 60 days of receipt, if clean claim is denied in whole or in part.

Sample: In the notification of a site visit letter, reviewer will request that the M+CO provide a list of unaffiliated provider claims that were paid in the six-month period ending with the month prior to the scheduled visit (the specific months should be specified in the letter). If contracted provider groups process claims, be sure to have the M+CO include a separate claims listing of the claims processed by its contracting groups. If the M+CO offers a point-of-service benefit that allows beneficiaries to receive services outside the plan's contracted provider/supplier network, be certain to have the M+CO include, and clearly identify POS-related claims included in this sample. Depending upon the number of enrollees in the POS product, the reviewer may, at their discretion, request a separate universe of POS-only claims for review. Upon receipt of the lists, approximately two weeks prior to the site visit, the reviewer will select 30 cases of plan claims and 30 cases of group claims (NOTE: if the plan contracts with multiple groups, select a sample that includes claims from at least three groups) in accordance with the random selection methods discussed in the Review Guide Instructions, under Sampling Methodology.
(Note: During focused reviews, HCFA staff may elect to increase sample sizes to 100 cases or more, as deemed appropriate by the Agency.) Five (5) to seven (7) days before the site visit, reviewer will notify the M+CO of the specific units of analysis. The M+CO will have all necessary documentation for the units of analysis available upon the reviewers' arrival onsite.

Column Explanations:

Name/HI Number: Self-explanatory. HI Number optional. Identifier may be the claim number, as defined by the M+CO's claims processing system; in addition, an enrollee identifier should also be used.

Date Claim Received: Self-explanatory.

Date Claim Paid: Use date on computer or other records. If there are complaints from providers or enrollees regarding nonpayment of claims, check to see whether checks are written but not mailed. This could indicate financial or other problems.

Clean Claim?: Using the definition in the *Review Guide*, under CP01 MOE, was the M+CO's determination of "clean" claim correct?
If problems with correctly identifying what is a clean claim, consider transferring result to AMO5.

Claim Paid in 30 Days? Regulations specify unaffiliated provider clean claims must be **paid** in 30 days.
Transfer result to CP02.

If no, was interest paid? If claim was not paid in 30 days, then interest must be paid at the rate used for purposes of 3902(a) of Title 31, United States Code for the period beginning on the day after the required payment date and ending on the date on which payment is made.

If non-clean claim, paid in 60 days? Non-clean claims must be paid or denied in 60 calendar days. Add total of non-clean claims paid in over 60 calendar days to denied claims on which a determination was not made in 60 calendar days (WS-CP2) to determine whether the M+CO meets CP03.

Appeals notice mailed if not processed in 60 calendar days? If not paid in 60 calendar days, appeal rights must be sent. Put in date appeals rights were sent to the enrollee.

Claim Processed Accurately? Was the service a Medicare-covered service or a benefit in the M+CO's subscriber agreement?
Was the payment determination correct, including charging the enrollee only appropriate co-payments?

Claims for emergency and urgent needed care are processed considering the enrollee's perception at the time the service was received; no prior authorization is necessary.
Transfer result to CP01.

Comments: Self-explanatory. Include comments here that will help to focus on trends (e.g., increasing length of time to process clean claims, reasons why claims are not accurately processed).